STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 S GREENWOOD SPRINGS DR GREENWOOD, IN46143

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S0000	This visit was for a standard licensure survey. Facility Number: 006218 Survey Date: 7-25/26-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor Carol Laughlin, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 08/16/11	S0000	No deficiancies cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0270	410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to follow its policy to review, at least quarterly, reports of management operations for calendar year 2010 quality monitoring activities. Findings: 1. Review of hospital policy H-PC 06-014, SECTION V: MAINTAINING THE GAIN - ACHIEVING AND SUSTAINING PERFORMANCE IMPROVEMENT, indicated Quality Council findings will be reviewed at least quarterly by the Medical Executive Committee and biannually by the Governing Board. 2. Review of governing board minutes for year 2010 indicated there were only 3 quarters when the governing board	S0270	Review of the minutes of the Medical Executive Committee for the 3rd Quarter, 2010 shows evidence of Quality Council performance improvement activities review in the meeting for each month in the quarter. Quality Council activities have been added as a standing agenda item for the Governing Board meetings.Monitoring will be accomplished through a review of the minutes of the Medical Executive Committee and the minutes of the Govenring Board on a monthly basis.Responsible Party: Director of Quality and Risk Management	08/28/2011

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	reviewed quality monitoring activities for calendar year 2010: 1st quarter - January 22, 2nd quarter - April 2 and 4th quarter - October 28. 3. Review of the Medical Executive Committee indicated the committee did not review any Quality Council findings in the 3rd quarter of year 2010. 4. On 7-26-11 at 10:45 am, upon interview, employee #A1 indicated there was no documentation of the governing board or medical staff executive committee having reviewed quality activities for the 3rd quarter in calendar year 2010. No documentation was provided prior to exit.			
S0308	15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review, the hospital	S0308	All Education Files have been audited for completeness by the	09/09/2011

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	failed to follow to orient 2 of 10 employees to applicable department policies. Findings: 1. Review of 10 personnel files indicated files PF#1 and PF#10 did not contain any documentation of department orientation. 2. On 7-26-11 at 2:15 pm, hospital staff was requested to provide the above documentation. Staff indicated there was no documentation and none was provided prior to exit.		Director of Education. An Excel spreadsheet has been developed to track the educational requirements for each associate. New Associate Orientation files will be audited weekly by the Director of Education while the associate is on orientation to assure that all needed documentation is present in the file. The results of the audit will be reported quarterly to Quality CouncilResponsible Party: Director of Education	
S0330	410 IAC 15-1.4-1(c)(6)(K) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.			

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	Based on document review and interview the hospital failed to follow its policy to maintain personnel records for 18 of 20 employees of post offer and subsequent physical examinations and 4 of 10 employees of immunizations. Findings: 1. Review of hospital Policy Number H-IC 05-001 indicated prospective and current employees will undergo periodic health evaluations as required by local and State licensure regulations. These may include, but are not limited to some or all of the following as described by State or Federal Law: Pre-placement history or physical (this may be by a personal physician, facility Medical Director or facility's preferred provider). Documentation of immunity to specific childhood diseases. (Rubella, Rubeola and Varicella) as required by State and Federal rules. Documentation of immunity to specific infectious diseases. (Hepatitis B). 2. Review of 20 personnel files indicated files PF#1, PF#2, PF#4, PF#5, PF#7, PF#8, PF#9, PF#10, P100, P200, P300, P400, P500, P600, P700, L1, L2 and L3 did not	S0330	An addendum will be added to the Employee Health policy that will allow the Employee Health nurse to conduct a post offer and all subsequent health screenings. The policy will go to the infection Control Committee for approval in September, 2011. All employee health files have been reviewed by the Employee Health nurse. Staff who do not have reliable documentation of immunization status will be contacted and requested to provide this documentation. If the documentation is not available, associates will have laboratory testing to determine the immunization status. Documentation of immunization status will be maintained in the Employee Health file. Responsible Party: Employee Health Nurse.	09/30/2011

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	have any documentation of a subsequent physical examination. 3. Review of 10 personnel files indicated files PF#1, PF#2 and PF#10 did not have documentation of immunity to specific childhood diseases. (Rubella, Rubeola and Varicella) as required by State and Federal rules. 4. Review of 10 personnel files indicated files PF#10 did not have documentation of of immunity to specific infectious diseases. (Hepatitis B). 5. On 7-26-11 at 2:15 pm, hospital staff was requested to provide the above documentation. Staff indicated there was no documentation and none was provided prior to exit.			

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S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on review of documents, the hospital failed to include 2 services provided by a contractor as part of its comprehensive quality assessment and improvement (QA&I) program. Findings: 1. Review of the facility's QA&I program indicated it did not include the contracted services off 1 of 2 ambulance services and blood bank. 2. On 7-26-11 at 10:45 am, employee #A5 was requested to provide the above documentation. At that same date and time, the employee indicated there was no documentation and none was provided prior to exit.	S0406	Monitoring criteria have been established for the ambulance service and the blood bank. THe criterion has been added to the Quality activities. 3rd Quarter, 2011 data will be reported to the Quality Council in October, 2011. Ongoing monitoring activities will be reported to the Quality Council on a quarterly basis.Responsible Party: Director of Quality and Risk Management	10/25/2011

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S0420	410 IAC 15-1.4-2.2 (a)(1) Reportable events Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the hospital: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both. (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both. (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that			

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	are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. (B) The following product or device events: (i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product. (ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism. (C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events			

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	that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital. (D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products. (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital. (v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or Stage 4 pressure ulcers			

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	acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital. (iv) Patient death or serious disability associated with a fall while being cared for in the hospital. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the hospital. (iv) Death or significant injury of a patient or			

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	staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital. Based on document review and interview, the hospital failed to include reportable events as part of its quality assessment and improvement (QA&I) program. Findings: 1. Review of the facility's QA&I program indicated it did not include reportable events. 2. On 7-26-11 at 10:45 am, employee #A5 was requested to provide the above documentation. At that same date and time, the employee indicated there was no documentation and none was provided prior to exit.	S0420	Reportable event information has been added to the agenda for Quality Council, Medical Executive Committee and The Governing Board. 2nd Quarter, 2011 data was reported to Quality Council, Medical Executive Committee and the Governing Board In August, 2011. Reportable Events will be reported on a quarterly basis.Responsible Party: Director of Quality and Rislk Management	08/23/2011

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A0604	410 IAC 15-1.5-2(f)(3)(D)(vii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. Based on document review and interview, the facility failed to ensure 3 of 3 foodservice workers to have an infection control policy on reporting information about their health and activities as they relate to diseases that are transmittable through food as required by 410 IAC 7-24-120. Findings included: 1. Review of policies/procedures on 7/26/2011 at 2:00 PM indicated the hospital did not have and infection control policy for diseases transmitted through food. 2. Retail Food Establishment Sanitation	A0604	The Nutritional Services policy H-NS-06-006 has been amended to include education for all Food Service associates regarding food bourne illness. Education will be provided to all new associates of the Food Service Department as part of the New Associate Orientation. An annual competence has been developed and will be given to all Food Service staff. All current Food Service staff were provided education on food bourne illness on August 1, 2011. The education included information on Salmonella, E. Coli and Hepatitis A.Responsible Party: The Infection Prevention and Control practitioner is responsible for the education of current staff. The Director of Education is responsible for New Associate	08/26/2011

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	Requirements 410 IAC 7-24-120 states, "The retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge, information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), if the food employee or applicant: (1) is diagnosed with an illness due to: Salmonella spp.; Shigella spp.; Shiga toxin-producing Escherichia Coli; or Hepatitis A virus; (2) has a symptom caused by illness, infection, or other source that is: (A) associated with an acute gastrointestinal illness, such as: diarrhea; fever; vomiting; jaundice; or sore throat with fever...." 3. Review of personnel files on 7/26/2011 at 2:00 PM revealed food service personnel L1, L2, and L3 did not have documentation of training regarding foodborne illnesses. 4. At 2:15 PM on 7/26/2011, staff members L4 and L5 acknowledged the hospital did not have an infection control		Education and ongoing competency assessment.	

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	policy for diseases transmitted through food.			
S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and interview, the facility failed to have a properly functioning communications system for 1 negative air pressure room. Findings: 1. On 7-25-11 at 10:47 am, employee #A6, upon interview, indicated if a negative air pressure room alarm was not responded to by hospital personnel within 1 minute, a facilities services employee would receive a signal from their electronic pager which they carried on their person. The employee also indicated at this time, his pager would receive the signal. 2. At that same above date and time, the	S1118	The alerting system including the pager system was corrected on August 5, 2011. Daily testing of the alarm system is being conducted by the Director of Plant Operations or his designate. Responsible Party: Director of Plant OperationsAll nursing staff will be educated on alarm response in September, 2011Responsible Party: Director of Clinical Operations	09/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 S GREENWOOD SPRINGS DR GREENWOOD, IN46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	negative air pressure device for Room 205 was activated. After more than 3 minutes, neither hospital personnel nor the pager responded.			
S1164	410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment. Findings: 1. On 7-25-11 at 9:30 am, employee #A1 was requested to provide documentation of PM on a renal dialysis machine and no documentation was provided prior to exit.	S1164	Preventive Maintenance has been completed on all dialysis equipment. The Director of Plant Operations will now keep a copy of all PM activity in the Plant Operations office. All preventive Maintence acitivity is reported quarterly to the Environment of Care Committee. Responsible Party: Director of Plant Operations	08/26/2011